## FAMILY PLANNING INITIAL HISTORY - PART I - MEDICAL HISTORY

Name		Age Do	_ Age Date of Birth		MEDICAL HISTORY ever had the following:	
	ur gran	HISTORY dparents, parents, brothers or sisters have any of the				
Yes	No	Bolded areas below are preconceptual topics	Yes	No	Bolded areas below are preconceptual topics	
105	110	Blood clots in arms/legs/chest			Allergies - Please list (including latex):	
		High cholesterol/triglycerides	$\dashv$		Are you taking medicine now? Please list:	
		Colon cancer			Blood clots in arms/legs/chest	
		Breast/ovarian/uterine cancer			Heart disease or high blood pressure	
		Heart disease or stroke (under age 50)			Migraine or frequent headaches	
		Blood Problems (Sickle cell anemia, hemophilia)			Numbness or visual changes	
		Diabetes			Cancer What type?	
		Alcoholism/drug abuse			High cholesterol/triglycerides	
		Birth Defects What type?			Blood problems (Sickle cell anemia, hemophilia, low iron)	
MENSTRUAL HISTORY					Thyroid problems	
TRST day of last menstrual period			-		Gall bladder disease	
			- - -		Surgery	
Yes	No	Bolded areas below are preconceptual			Kidney or bladder problems	
		Age periods began			Liver disease (hepatitis, mono, jaundice)	
		Do you have a period every month?			71.1	
		Do you bleed between periods?			Diabetes	
		Do you have cramps?			Epilepsy or convulsions	
		Do you take medication for cramps?	_		Rubella or shot for rubella (German measles)	
		Is the flow: ☐ Light ☐ Medium ☐ Heavy				
		Have you had sex without birth control since you	r		Tetanus vaccine. When:	

Have you had sex without birth control since your last period? When?

## YOUR PREGNANCY HISTORY YOUR BIRTH CONTROL HISTORY How many times have you been pregnant?\_\_\_\_\_ Method you are using today \_ Method you would like to start today\_\_\_ Age at first pregnancy\_ Are you breast-feeding? ☐ No ☐ Yes Are you planning on having children in the future? No Yes Method **Problems** Method **Problems** At what age? IUD: Pill: Brand(s) Type Yes No Check all that apply to your pregnancy history Foam Norplant In what years did you have a baby? Condoms Depo Provera I have had an abortion(s) Date: \_\_\_\_\_ Weeks pregnant \_\_ Diaphragm Emergency Contraception I have had a miscarriage(s) Date: \_\_\_\_\_ Weeks pregnant \_\_ YOUR PERSONAL HISTORY I have had a baby less than 5 2 pounds, or more than 9 pounds at birth Yes Family Planning services do not require parental permission When I was pregnant, I had a history of high blood Do you exercise? pressure, diabetes or had a baby with birth defects Do you smoke cigarettes? Amount YOUR GYNECOLOGICAL HISTORY Do you douche? Date of last PAP \_\_\_\_\_ Results\_\_\_ Have you ever had the following: Is anything causing you stress right now? Yes **Bolded** areas below are preconceptual topics If you are under 18: Is there an adult with whom you feel comfortable talking about sexuality? Abnormal PAP smear Date: \_\_\_\_\_ Treatment: \_\_\_ If you are under 18: Have you discussed this visit with your parents? Breast disease PERSONAL NUTRITIONAL INFORMATION Ovary problems How many servings do you eat of the following every day: Food Number of Servings each day Uterine problems Milk, Cheese, other dairy products Genital warts/HPV Chips, cakes, pies Meat, fish, poultry, eggs or beans Gonorrhea Fruits and vegetables Chlamydia Bread, cereals, grains Caffeine (coffee, tea, pop, chocolate) Syphilis Please answer the following questions: How often do you skip meals? **Genital herpes** Is your weight: ☐ Just about right ☐ Too heavy ☐ Too Thin Have you ever vomited or used laxatives to lose weight? Pain or other problems with sex ☐ No ☐Yes When was the last time? Are you on a special diet? (e.g., vegetarian, diabetic) ☐ No ☐ Yes If yes, please describe\_ Are you taking: ☐ Vitamins ☐ Iron ☐ Folic Acid ☐ Calcium Mammogram Date \_\_\_ Other supplements, herbs or weight loss preparations: Vaginal infections

Staff assessment: ☐ Adequate ☐ Inadequate

Patient signature \_\_\_\_\_

Comments:

Staff signature \_\_\_

Did your mother take DES during pregnancy?

Information given(if DOB < 1975)